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CONSULTANT OBSTETRICIAN AND GYNAECOLOGIST

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Factors Affecting Supply of Health Services and Medical professionals in Rural Areas

Introduction: I am:

- an Australian trained specialist Obstetrician and Gynaecologist and have worked in Wodonga, Victoria for 32 years continuously since 1979.
- a Fellow of Royal Australian & New Zealand College of Obstetrics and Gynaecology (RANZCOG) and was the representative on Council for 130 Provincial Fellows from 2003 to 2005.
- a Member of the National Association Of Specialist Obstetricians & Gynaecologists, (NASOG) and Rural Doctors Association Australia (RDAA).
- had the honour to being awarded the RDAA Australian Rural Doctor of the Year, 2010.
- the Chair of the Specialist Obstetrician Locum Scheme (SOLS), a federal government funded locum scheme for rural obstetricians and have done over 20 locums in most states of Australia.
- Associate Professor at the UNSW Rural Clinical School based in Albury, NSW where I teach Women's Health to 4th, 5th and 6th year medical students.
- have been involved in the local organization Border Medical Recruitment Taskforce since its inception in 2007 (www.bordermedicalrecruitment.com.au)
- the organizer of the Border Medical Association Scholarship program. This innovative program supports and mentors Year 12 students from our region through university and post-graduate study, in order to encourage them to return after they graduate. Scholarships have been awarded to 85 local students since 1990, many of whom are now returning to the country as doctors (www.bordermedical.com.au)

Critical Shortage of Rural Doctors

It is well known that the shortage of doctors living and working in the country is a key issue. For many years the workforce has been supported by overseas medical graduates and rural towns could not have managed without them.

However, about 75% do not stay in the country after they have attained full registration, preferring a city practice (Bogong Regional Training Network 2011)

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It is also known that 75% of rural Australian students return to the country once they have completed their training. This percentage increases if part of their post-graduate training is completed in the country, and if they have a rural partner.

There are 30% of Australians who live in the country, but rural students are under-represented in the medical schools. There are enough doctors in Australia (with more now in training), but they are unevenly distributed, with relatively more practising in the cities, for many reasons.

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Incentives from the federal government have gone some way to encourage doctors to consider practising in the country, but more practical incentives need to be done.

The federal government Rural Australian Medical Undergraduate Scholarship administered by the National Rural Health Alliance is a popular and worthwhile program which encourages and financially supports rural students throughout their entire student years. The requirement they have a rural medical practitioner as a mentor is also applauded, as this exposure to rural medicine is beneficial to rural students.

However, the higher complexity of rural practice, increased hours on-call and the lack of specialist support deter many younger doctors from considering rural practice.

Another factor is that people living in the country either, do not have private health or, choose not to use it. This is because there are few private facilities in a rural hospital and no or little choice in GP's or Specialists, so the doctor is bound by the Medicare rates of remuneration which are woefully inadequate.

Rural Loading of Medicare Items must be considered as a matter of urgency

Any government program which supports rural students being accepted into Medicine needs to be enhanced. Rural students in secondary schools are disadvantaged compared to city students, so a rural loading of the TER scores would improve the number of rural students entering medical studies and subsequently returning to the country after they graduate.

Growing up in a rural environment is the strongest factor in deciding to live and practice in the country in the future.

The Rural Clinical Schools established by the Federal Government have been a huge success in both exposing city students to rural life and allowing rural students to study in the country, sometimes in their own town such as here in Albury Wodonga. However, finding suitable teachers for these students, when rural doctors are so stressed with their workload that time and commitment are important factors, can be a major problem.

Financial incentives to encourage more clinical teachers must be considered.

In Albury Wodonga, an organization called Border Medical Recruitment Taskforce (BMRT) was established in 2007 to address a critical shortage of local doctors in most craft groups in this area. This received funding from local government, local businesses and local doctors. The BMRT has been a huge success; since 2007, over 40 new General Practitioners and over 30 new specialists have been recruited to Albury Wodonga. Every rural town could follow this example, with government support, as the results have been very encouraging.

Federal government support of local recruitment programs would be worthwhile.

The procedural general practitioner programs, first tried in Queensland and now in NSW and Victoria, have been a huge success in training more skilled doctors to be able to practise in rural and remote areas. These programs need to be fully supported by the Federal Government and suitable post-graduate training posts need to be securely funded.

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The funding of infrastructure needed to practise high quality medicine in the country needs to be reviewed because funding, spent by state governments, has been mostly in politically marginal seats, rather than on clinical needs.

Large referral centres, like Albury Wodonga have historically received less funding than is required for their referral population.

For example, the lack of a public coronary catheter laboratory in Albury Wodonga with a population of over 250,000 people is of concern, especially when there are 3 laboratories in Geelong, which cover a similar population.

The application of the Remoteness Area Classification has not ensured appropriate distribution of funds and should be reviewed.

Since 2002, both the Coalition and Labour federal governments have supported General Practice Education Training (GPET); this program has been successful with increasing number of graduates commencing this rural-based training. Graduates now are joining rural practices and the program has been a huge success in increasing younger doctors to rural practices. Continued financial support is essential to keep this program going.

The major, continued defect in the funding of rural medicine in Australia is the federal and state divide of responsibility. There continues to be both cost shifting and tedious blame shifting between the federal and state governments.

Duplication of services and administration is both costly and unnecessary; I believe that efficiencies can only be realized if the federal government takes over responsibility for health, and local health authorities with equal representation from the private and medical communities, manage the funds.

The cost saving to Australian taxpayers by eliminating all state and territory health departments has been estimated to be over $20 Billion!

While technology can be used to support doctors in remote areas of Australia, teleconferencing, as a way of dealing with rural health problems, is not efficient or effective. Technology cannot replace a local doctor making clinical examinations in situ.

The answer is to encourage the placement of more doctors in rural settings, rather than patients encouraged to consult a city doctor on line, which is an impractical and dangerous trend. The enormous cost of these services would be better spent on increasing the Medicare rebate in the country and increasing the viability of rural practice.

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